FORM 110-F
FATALITY
January, 2005

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, KY 40601

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
Every section should be filled in. If a section is not applicable, fill in the blank with N/A.

_____ Decedent

_____ Insurer/Self-Insured/Self-Insurance Group

_____ Social Security Number Date of Birth

_____ Insurer's Address

_____ Address

_____ City, State Zip Code

_____ City, State, Zip Code

_____ Employer

_____ Other participating parties

_____ Address

_____ Address

_____ Zip Code

_____ City, State, Zip Code

INJURY

Date of Injury: _____ Date of Death: _____
County in which injury occurred: _____
Brief description of occurrence resulting in injury:_____
_____
Nature of injury(ies) including body part(s) affected: _____

MEDICAL INFORMATION

Medical expenses paid: $_____ Date of last medical payment: _____ Medical expenses unpaid or contested: $_____

WORK INFORMATION

Type of work at time of injury: _____
Average weekly wage at time of injury: _____

BENEFIT AND SETTLEMENT INFORMATION

Amount and duration of temporary total disability paid to date: $_____ X _____ = $_____
Per week No. of weeks Total

If death occurs within 4 years of the injury, has a lump sum payment been made to decedent's estate per KRS 342.750(6)? _____ Amount $_____ Monetary terms of settlement: $_____, to be paid as follows: ___ lump sum , ___ weekly for_____ weeks, ____ by annuity, ___ other____ Total settlement amount: $_____
Settlement computation: _____

Proceeds of the settlement are allocated among qualifying dependents as follows:

Name	Date of Bi	Social Secu Number	Relationshi Deceden	Address	Weekly ber	Duratio

Relationship of claimant (party signing settlement agreement) to decedent's minor dependents:
_____

Is decedent survived by any minor dependents other than those listed above? _____ If so, please list below:

Name	Address	Date of Birth	Guardian/Custodial

ATTACHMENTS

Please attach certified copies of the following documents:

1. Death Certificate
2. Marriage License
3. Birth certificates of minor dependents

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):

_____Other responsible parties against whom further proceedings are reserved: _____

This the _____ day of _____, 20___.

_____	_____
Attorney or representative for claimant (Signature)	Claimant (Signature)
_____	_____
Attorney or representative for claimant (Name Typed)	Attorney or representative for employer (Signature)
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
	_____
	Attorney for Special Fund (Div. of Workers' Comp Funds)

DO NOT WRITE OR MARK BELOW THIS LINE

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same in hereby **APPROVED.**

This the _____ day of _____, 20____.

_____
Administrative Law Judge